FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009720

Facility Name: HELEN LEWIS SMITH PAVILION

Address: 519 S FIFTH STREET (Number) FAIRBURY (City) 62664 (Zip Code)

County: LIVINGSTON

Telephone Number: (815) 692-2346 **Fax #** ( )

IDPA ID Number: 370704576001

Date of Initial License for Current Owners: 1967

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) CRAIG L. ATER
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,393	1,592	0	8,985	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	6,521	0	6,521	12
13	DD 16 OR LESS					13
14	TOTALS	7,393	8,113		15,506	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 86.46%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1989

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 0 and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[XX]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	8541	8541	0
IPA	7396	7393	3
medicare	0	0	0
	15937	15934	

IPA BEDHOLDS	0
PP BEDHOLDS	62
PP CONVERS	366

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	97,162	8,402		105,564		105,564	0	105,564			1
2	Food Purchase		58,896		58,896		58,896	0	58,896			2
3	Housekeeping	49,590	7,414		57,004		57,004	0	57,004			3
4	Laundry	27,172	5,114		32,286		32,286	0	32,286			4
5	Heat and Other Utilities			108,290	108,290		108,290	0	108,290			5
6	Maintenance	50,208	27,779	9,501	87,488		87,488	0	87,488			6
7	Other (specify):*							0				7
8	TOTAL General Services	224,132	107,605	117,791	449,528		449,528		449,528			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800	0	4,800			9
10	Nursing and Medical Records	496,156	34,725	49,331	580,212		580,212	0	580,212			10
10a	Therapy		435	60	495	(495)		0				10a
11	Activities	26,932	824	0	27,756		27,756	0	27,756			11
12	Social Services	18,161	20	803	18,984		18,984	0	18,984			12
13	Nurse Aide Training	1,292	250		1,542		1,542	0	1,542			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	542,541	36,254	54,994	633,789	(495)	633,294		633,294			16
	C. General Administration											
17	Administrative	42,191			42,191		42,191	0	42,191			17
18	Directors Fees							0				18
19	Professional Services			90,512	90,512		90,512	(372)	90,140			19
20	Dues, Fees, Subscriptions & Promotions			36,653	36,653	(26,901)	9,752	(2,960)	6,792			20
21	Clerical & General Office Expense	63,645	7,074	9,613	80,332		80,332	0	80,332			21
22	Employee Benefits & Payroll Taxes			133,462	133,462		133,462	0	133,462			22
23	Inservice Training & Education			765	765		765	0	765			23
24	Travel and Seminar			4,381	4,381		4,381	(2,382)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			20,338	20,338		20,338	0	20,338			26
27	Other (specify):*			14,075	14,075		14,075	(14,075)				27
28	TOTAL General Administration	105,836	7,074	309,799	422,709	(26,901)	395,808	(19,789)	376,019			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	872,509	150,933	482,584	1,506,026	(27,396)	1,478,630	(19,789)	1,458,841			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			119,464	119,464		119,464	0	119,464			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			0				0				32
33	Real Estate Taxes			13,686	13,686		13,686	(13,686)				33
34	Rent-Facility & Grounds			6,396	6,396		6,396	0	6,396			34
35	Rent-Equipment & Vehicles			1,125	1,125		1,125	0	1,125			35
36	Other (specify):*							0				36
37	TOTAL Ownership			140,671	140,671		140,671	(13,686)	126,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					495	495	0	495			39
40	Barber and Beauty Shops	0	100	0	100		100	0	100			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					26,901	26,901	0	26,901			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		100		100	27,396	27,496		27,496			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	872,509	151,033	623,255	1,646,797	0	1,646,797	(33,475)	1,613,322			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	0	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	0	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	(13,686)	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(136)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,382)	24		19
20	Contributions	(75)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(372)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,000)	27		24
25	Fund Raising, Advertising and Promotional	(2,824)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,475)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,475)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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ıe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically

The amounts in the Adj. Summary column are linked to pages Summary A and B

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustment

STATE OF ILLINOIS **Page 5A**

Facility Name HELEN LEWIS SMITH PAVILION

ID# 0009720

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	35	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 7**	0
8	**Laundry for Non-Patients**	0		**Line 8**	0
9	**Non-Straightline Depreciation**	0	30	**Line 9**	0
10	**Interest and Other Investment Income**	0	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13	**Sales Tax**	0	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	(13,686)	33	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17	**Non-Care Related Fees**	(136)	20	**Line 16**	0
18	**Fines and Penalties**	0		**Line 17**	0
19	**Entertainment**	(2,382)	24	**Line 18**	0
20	**Contributions**	(75)	27	**Line 19**	(75)
21	**Owner or Key-Man Insurance**	0		**Line 20**	(2,900)
22	**Special Legal Fees & Legal Retainers**	(372)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0		**Line 22**	0
24	**Bad Debt**	(14,000)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(2,824)	20	**Line 24**	(2,783)
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(14,677)
29	**Non-Paid Workers**	0	0	**Line 28**	(19,700)
30	**Donated Goods**	0	0	**Line 29**	(19,700)
31	**Amortization Expense**	0	0	**Line 30**	0
32				**Line 31**	0
33				**Line 32**	0
34				**Line 33**	(13,686)
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(13,686)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(93,473)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0		0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0		0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0		0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0		0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0		0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0		0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0		0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0		0	0	0	0	0	0	0	0	0	18
19	Professional Services	(372)	0		0	0	0	0	0	0	0	0	(372)	19
20	Fees, Subscriptions & Promotions	(2,960)	0		0	0	0	0	0	0	0	0	(2,960)	20
21	Clerical & General Office Expenses	0	0		0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0		0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0		0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,382)	0		0	0	0	0	0	0	0	0	(2,382)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0		0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(14,075)	0	0	0	0	0	0	0	0	0	0	(14,075)	27
28	**TOTAL General Administration**	(19,789)	0	0	0	0	0	0	0	0	0	0	(19,789)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,789)	0	0	0	0	0	0	0	0	0	0	(19,789)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0		0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	0	0	0		0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(13,686)	0	0		0	0	0	0	0	0	0	(13,686)	33
34	Rent-Facility & Grounds	0	0	0		0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0		0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,686)	0	0	0	0	0	0	0	0	0	0	(13,686)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,475)	0	0	0	0	0	0	0	0	0	0	(33,475)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe HELEN LEWIS SMITH PAVILIOP # 0005720 Report Period Beginning 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES Show Pgs 6A thru 6 Show Pgs 6E thru 6 Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		$ 0		100.000%	$ 0	$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$			$	$ *	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing th of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPO

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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ıe name(s)
)RTS.

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$ 0	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10											0	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	0	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		1987	$ 73,130	1
2			1999	0	2
3	TOTALS			$ 73,130	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49				$ 106,494	$		$	$	$	4
5					915,287						5
6											6
7											7
8											8
	Improvement Type**										
9	1967			1967	74,565						9
10	1969			1969	5,389						10
11	1974			1974	5,897						11
12	1975			1975	2,592						12
13	1979			1979	1,151						13
14	1981			1981	2,613						14
15	1985			1985	54,949						15
16	1987			1987	50,516						16
17											17
18	Oil Tank			2000	12,435						18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	Book Depreciation					23,465		23,465		938,189	35
36	TOTAL (lines 4 thru 35)				$ 1231888	$ 23,465		$ 23,465	$	$ 938,189	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 0	$ 3,506	$ 3,506	$		$ 3,506	37
38	Current Year Purchases	78,468						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 78,468	$ 3,506	$ 3,506	$		$ 3,506	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 26,971	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 26,971	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 941,695	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm $ 1,125 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		250		250
3	Classroom Wages (a)		1,292		1,292
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,542	$	$ 1,542
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,542			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 0	$		$	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			0				4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				435		435	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab / X-ray	39/3				60			60	13
14	TOTAL			$		$ 60	$ 435		$ 495	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj 0
st adj 0
Ot adj 0

drugs 0

Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,477	$	1
2	Cash-Patient Deposits	1,376		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	126,455		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,996		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(49,273)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 137,031	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	73,130		13
14	Buildings, at Historical Cost	4,139,717		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,999,285		16
17	Accumulated Depreciation (book methods)	(4,897,371)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify):	0		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,314,761	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,451,792	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,736	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,376		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	0		30
31	Accrued Taxes Payable (excluding real estate taxes)	0		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,069		32
33	Accrued Interest Payable	0		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 123,181	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	21,718		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 21,718	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 144,899	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,306,893	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,451,792	$	48

***(See instructions.)**

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,430,927	1
2	Restatements (describe):		2
3	audit Adjustment	202	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5**	$ 1,431,129	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(124,236)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (124,236)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,306,893	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,487,646	1
2	Discounts and Allowances for all Levels	(37,530)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,450,116	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	0	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	673	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	37,615	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,925	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 40,213	23
	D. Non-Operating Revenue		
24	Contributions	30,697	24
25	Interest and Other Investment Income***	1,481	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 32,178	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		54	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 54	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 1,522,561	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 449,528	31
32	Health Care	633,789	32
33	General Administration	422,709	33
	B. Capital Expense		
34	Ownership	140,671	34
	C. Ancillary Expense		
35	Special Cost Centers	100	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,646,797	40
41	**Income before Income Taxes (line 30 minus line 40)****	(124,236)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (124,236)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number HELEN LEWIS SMITH PAVILION # 0009720 Report Period Beginning 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,760	1,760	$ 36,598	$ 20.79	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	6,256	6,849	112,077	16.36	3
4	Licensed Practical Nurses	2,759	2,884	45,786	15.88	4
5	Nurse Aides & Orderlies	27,600	29,475	292,122	9.91	5
6	Nurse Aide Trainees	172	172	1,292	7.51	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	941	1,095	9,573	8.74	8
9	Activity Director					9
10	Activity Assistants	2,879	3,119	26,932	8.63	10
11	Social Service Workers	2,028	2,126	18,161	8.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,261	12,221	97,162	7.95	15
16	Dishwashers					16
17	Maintenance Workers	4,841	5,164	50,208	9.72	17
18	Housekeepers	8,540	9,283	49,590	5.34	18
19	Laundry	3,581	3,949	27,172	6.88	19
20	Administrator	2,080	2,080	42,191	20.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,388	4,693	63,645	13.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,086	84,870	$ 872,509 *	$ 10.28	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		4,800		36
37	Medical Records Consultant		1,000		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,188		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		803		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 7,791		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 28,930		50
51	Licensed Practical Nurses		12,151		51
52	Nurse Aides		5,010		52
53	TOTAL (lines 50 - 52)		$ 46,091		53